# Improving Patient Safety: What Will It Take?


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# To Err is Human
# Building a Better Healthcare System

- 1999 IOM Report
- Between 44,000 and 98,000 die as a result of medical errors annually
  - Would be the 8th leading cause of death
  - Ranks higher than MVAs, breast CA, AIDS
- Total costs: $17-29 billion

# Patient Safety 101

- Error- failure of a planned action to be completed as intended (error of execution) or use of a wrong plan to achieve an aim (error of planning)
- Can occur at all stages of the care process: diagnosis, treatment, palliation, prevention
- Not all errors result in harm
- Not all adverse events are due to errors; must be preventable

# 44,000-98,000 Lives

Based on extrapolation from two studies:

- Analysis of Utah and Colorado hospitalizations: adverse events occurred in 2.9% of which about 30% were negligent and death occurred in 6.6% (Thomas, Medical Care 2000)
- Analysis of New York hospitalizations: adverse events occurred in 3.7% of which 27% were negligent and death occurred in 13.6%

# Is It Really That Bad?

- Are all errors preventable?
- Would most physicians agree that an error was made?
- Bad things happen to sick patients

# Could It Be Worse?

- Medical records are incomplete
- Estimates are based solely on hospital data
- 35% of physicians and 42% of the public reported errors in their own or a family member's care (Blendon, NEJM 2002)

# Improving Patient Safety: Recognizing Problems and Opportunities

- Error prevention means designing the health care system at all levels to make it safer
- Building safety into processes of care is more effective to reduce errors than blaming individuals
- The culture of health care organizations must support prevention of future errors by continuous learning rather than focusing on blame

# Developing a Culture of Safety

- Supports reporting of errors (those resulting in adverse events as well as near misses) without suggesting that people are not responsible or accountable for their actions
- Encourages and supports employees to come forward in the interests of patient safety without becoming ‘blame-free’

# Characteristics of Successful Reporting Systems

- Nonpunitive
- Confidential
- Independent
- Expert analysis
- Timely
- Systems-oriented
- Responsive

(Leape, NEJM 2002)

# Where is the Disciplinary Line?

Categories of behaviors that lead to errors:

- Human error- an inadvertent slip or mistake by which a person does something other than what they should have done, causing harm or risk of harm
- Negligence- failure to exercise the skill, care, and learning expected of a reasonable prudent provider
- Intentional rule violations
- Reckless conduct- conscious disregard of a visible, significant risk

(Marx, Patient Safety and the “Just Culture”, 2001)

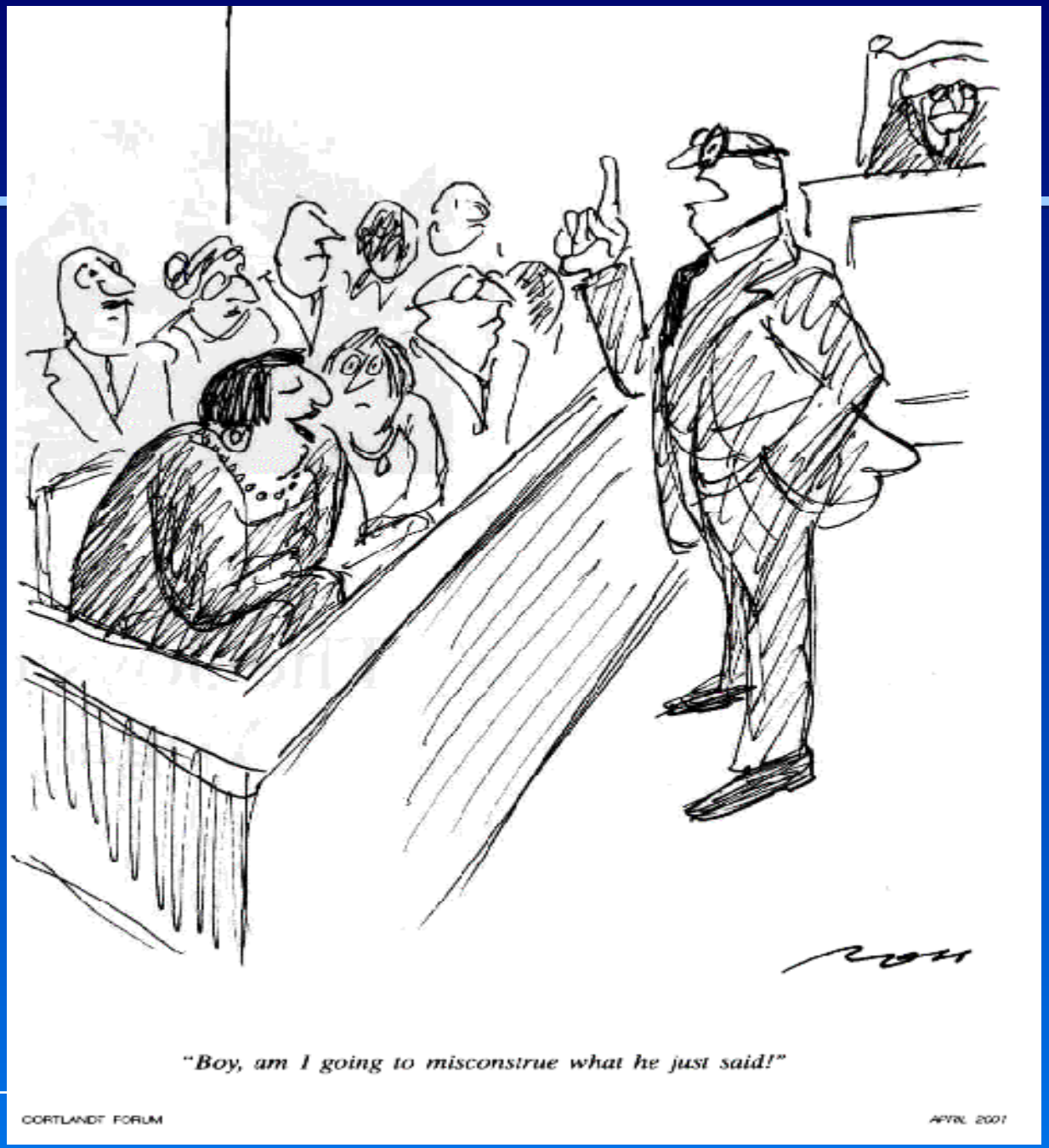
# Where is the Disciplinary Line?

- Much of our disciplinary system hinges on outcome; a reporting system should not
- Rule-based disciplinary decision-making-learning organizations have raised the disciplinary threshold to intentional rule violations
  - E.g. FAA will forego disciplinary action for inadvertent, non-deliberate violations

# Where is the Disciplinary Line?

Gray areas:

- Negligence- e.g. an employee should have known but was unaware of the risk they were taking
- Repetitive errors- in part, this depends whether it is the nature of the task or the person that is error prone


"Boy, am I going to misconstrue what he just said!"
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# Reporting Systems

- Are they supportive or detrimental to your system safety efforts?
- Have you balanced the need for communication with the need for deterrence and punishment?

# What about Risk Management?

- Some states (not NJ) preserve confidentiality of voluntary reporting systems
- Could openness and honesty be the best policy?
  - Lexington VA experience

# Patient Safety Practices

- Defined as a type of process or structure whose application reduces the probability of adverse events
- Criteria for prioritization:
  - Potential impact of the practice
  - Strength of the evidence
  - Implementation

# Low Hanging, Cheap Fruit

- Appropriate use of thromboembolism prophylaxis
- Perioperative beta-blockers
- Sterile barriers during placement of central IV catheters
- Appropriate surgical antibiotic prophylaxis
- Active patient participation in informed consent process
- Use of antibiotic impregnated catheters

*"I will now take questions from the floor"*